

■ The needs of the student — if the student is likely to require support or special consideration in their transition into the medical workforce, then early notification is essential.

The Board does not want to know about every distressed, unwell or disabled student. Clearly, most of these students are not impaired within the Board's definition. However, if the individual has special needs, there is great value in early notification, as the Board needs time to ensure that a suitable internship can be devised.

The NSW Medical Board's approach to impaired students is illustrated by the case study given in the Box.

Need for a culture change

Notification of both students and doctors requires a shift in culture. The profession is historically reluctant to "dob in a mate", and problems are frequently "swept under the carpet" or poorly managed in "corridor consultations". Some States and Territories have legislated a statutory obligation to notify impaired practitioners to the Board. There are pros and cons to this approach. Of greatest concern is the potential for mandatory notification preventing unwell doctors from seeking treatment.

Flexible approaches to internships

Internships used to be extremely regimented and prescriptive. In NSW, and I believe in most other jurisdictions, there is now a much more flexible approach. Internships can be individualised in terms of hours, terms, location and duration, provided that the core competencies of internship are achieved. However, flexibility does raise important employment issues. Unimpaired interns have expressed concerns about favouritism and reverse discrimination. In addition, hospitals do not have a limitless capacity to accommodate

Case study — a medical student referred to the NSW Medical Board

Dr A was a final-year student when first referred to the Medical Board. He was a mature-age student in an undergraduate program who had been displaying inappropriate behaviour in his clinical terms, and had refused all offers of help by the Faculty. When he was notified by the Faculty, he was in a manic episode of bipolar disorder.

The student was independently assessed by a psychiatrist nominated by the Board and placed in a monitoring program. He had a further manic episode, but it was detected early because of the support structure around him. We were able to intervene rapidly and his condition stabilised quite quickly with treatment. We required him to have a treating psychiatrist, and we had his authorisation for the psychiatrist to let us know if he did not comply with treatment or if his health deteriorated.

He attended for regular review by the Board-nominated psychiatrist and for Board review interviews on a six-monthly basis. On graduation, we notified his employer of his conditions of registration, as it was important that his internship was conducted in an informed and supportive environment. He did very well, and is now in specialist training. (All colleges have stopped denying specialist training to doctors with conditional registration.)

interns with special needs. In NSW, some hospitals are very good at looking after impaired interns, but it is unfair to overload them.

Conclusions

Medical boards discharge their responsibility for public protection in a variety of ways. The structured, compassionate and fair management of impaired practitioners is an important component of a board's work. The NSW Medical Board has 10 years' experience with student registration, and commends it to other jurisdictions, and to students themselves, as a valuable and mutually beneficial approach. □

Changes to the South Australian *Medical Practitioners Act 1983*

David H Wilde

THE SOUTH AUSTRALIAN *Medical Practitioners Act 1983* is currently being reviewed and the new Bill is before Parliament. The new Medical Practitioners Act will call for the registration of medical students with the South Australian Medical Board, and will aim to be supportive of medical students. It will also contain new provisions for protecting the public.

[The comments made in this article and given at the conference were appropriate at the time. Since then, the South Australian Parliament was prorogued and an election held. The proposed new Medical Practitioners Act had not passed both Houses of the Parliament and has therefore lapsed. At this point in time, I am not aware of what the new Government may include in a Bill it may wish to introduce.]

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Registration of medical students

Registration of students has several important pluses for students. It clearly brings them into the ambit of the profession with some status, and it helps identify students who, because of ill-health, may not be able to enter certain areas of clinical practice after completing their studies. Early counselling and input into those professional pathways that will be available can only be of benefit to all concerned.

Registration of students is not a new concept. New South Wales has already adopted this approach and it is currently on the agenda of several other States.

New provisions for protecting the public

The approach of the Medical Board in South Australia has always been to support both individual members and the medical profession in general while retaining its statutory requirement of public protection.

Under the new Act, the SA Medical Board will require much more information on the health of individual doctors and students, particularly in relation to infectious diseases. While transmission rates of bloodborne viruses from health-care professionals to patients are low, such transmissions do occur, with potentially serious consequences for patients.

As part of the Board's role of public protection, it is appropriate that the Board is made aware of practitioners who are infected with bloodborne viruses so that appropriate protective steps can be put in place. It should be emphasised that these steps would not necessarily or routinely mean denying the right to practise medicine.

There is already a requirement in the current Act for a treating doctor to report to the Board, in writing, the details of patients who are medical practitioners, and are suffering from a condition which impairs or may impair their ability to practise medicine safely. The new reporting requirements now place a responsibility on the patient who is a doctor to also report his or her own health status to the Board.

Overall, the SA Medical Board will maintain a careful balance of confidentiality, support for the medical profession, including medical students, while looking after the best interests of the general public. □

Return to work for junior doctors after ill-health

Jillann F Farmer

THE MEDICAL BOARD OF QUEENSLAND, through its Health Assessment and Monitoring Program, provides active support to the medical profession, particularly to doctors recovering from impairment (ie, illness which has been serious enough to affect their capacity to practise). There are about 50 new referrals to the program each year — 37% have a psychiatric illness, 45% involve drug misuse (other than alcohol), and 7% alcohol misuse. At least 60% of practitioners who come to the Board's attention have a dual diagnosis (eg, depression and drug misuse).

Board databases do not specifically collect information on the stage that the doctor has reached in his or her career at the time of illness. However, approximations can be made through manual collation of recent data, with the rough figures on diagnoses in junior doctors being 17% alcohol misuse, 17% other drug misuse, 25% depression, 8% post-traumatic stress disorder, and 17% bipolar affective disorders.

Case histories

The following case histories illustrate the work of the program with doctors recovering from drug misuse and/or mental illness.

Identifying details have been altered in the interests of practitioner confidentiality. However, details pertaining to significant events, milestones, Board intervention and outcomes have been reported as accurately as is compatible with maintaining confidentiality.

Case 1

This young doctor (less than two years after graduation) was rostered to cover ICU alone, with a consultant on remote

call. In an endeavour to control stress-related symptoms, he treated himself with benzodiazepines. Their use escalated, as did his symptoms of poor sleep, poor appetite, weight loss and social withdrawal. Recognising that his symptoms were worsening, he sought relief in S8 drugs, which he obtained from the operating theatres (adjacent to ICU). His drug misuse continued (varying in severity) over several years. He was eventually found unconscious in the theatre change rooms.

The Board was notified. His primary and most urgent need was for detoxification because of long-term misuse of benzodiazepines and opiates. Once this had been undertaken, an assessment of his fitness to practise was arranged by the Board.

A minimum of three months off work was needed, but he had no income protection. Showing considerable initiative (particularly given the severity of his illness), he started a dog-grooming business, and managed to support himself through a lengthy period of time out of the medical workforce.

When his medical condition had stabilised, he secured a new medical post with Board support. He was required to fully disclose his medical history to his supervisor, to undergo random urine drug screening (up to 16 tests per month), and was subject to monthly workplace reports from his supervisor to the Board. With the passage of time, reporting and testing requirements have been gradually reduced. He is progressing very well, and there has been no relapse.

Challenges

- He needed time off without income protection.
- He needed to overcome the label of "impaired doctor".
- Once he had left the hospital he had been working in, there was no sense of duty of care elsewhere.
- His vulnerable position with his employer necessitated intervention and advocacy even after he was employed.

Lessons

- There is a need for education of peers to monitor junior doctors and, if necessary, initiate early intervention. If this

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